LOS ANGELES COUNTY COMMISSION ON HIV

3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-4748
www.hivcommission-la.info

While not required of meeting participants, signing-in constitutes public notice of attendance. Presence at meetings is recorded solely based on sign-in sheets, and not signing-in constitutes absence for Commission members. Only members of the Commission on HIV are accorded voting privileges, thus Commissioners who have not signed in cannot vote. Sign-in sheets are available upon request.

COMMISSION ON HIV
MEETING MINUTES
October 14, 2010

MEMBERS PRESENT	MEMBERS PRESENT *(cont.)*	PUBLIC *(cont.)*	OAPP/HIV EPI STAFF
Carla Bailey, *Co-Chair*	Stephen Simon	Aaron Fox	Kyle Baker
Anthony Braswell, *Co-Chair*	Robert Sotomayor	Aaner Garcia	Elizabeth Escobedo
Sergio Aviña	Tonya Washington-Hendricks	Thelma Garcia	Carlos Vega-Matos
Al Ballesteros	Kathy Watt	Shawn Griffin	Juhua Wu
Robert Butler		Philip Hendricks	
Fredy Ceja		Jason Houchen	
James Chud	**MEMBERS ABSENT**	Miki Jackson	**COMMISSION STAFF/CONSULTANTS**
Nettie DeAugustine	Carrie Broadus	David Kelly	
Whitney Engeran-Cordova	Lee Kochems	Ayanna Kiburi	Diane Burbie
Douglas Frye	Abad Lopez/Ron Osario	Dustin Lewis	Erinn Cortez
David Giugni	Mario Pérez	Victor Martinez	Dawn McClendon
Jeffrey Goodman	Juan Rivera	Gene McCarty	Jane Nachazel
Thelma James	Fariba Younai	Henry Nickel	Glenda Pinney
Michael Johnson		Joanne Oliver	James Stewart
Bradley Land		Jo Paredes	Craig Vincent-Jones
Ted Liso	**PUBLIC**	Terri Reynolds	Nicole Werner
Anna Long	Christopher Agu	Nicholas Rocca	
Quentin O'Brien	Herman Avilez	Treli Triantafillon	
Jenny O'Malley	Betsy Cardenas	Sharon White	
Dean Page/Terry Goddard	Pamela Chiang	Ingrid Weines	
Angélica Palmeros	Kevin Farrell	Aaron Fox	
Karen Peterson	Miguel Fernandez	Jason Wise	
Jennifer Sayles	Susan Forrest		

1. **REGISTRATION**: Registration began at 8:30 am.

2. **CALL TO ORDER**:
   - **A. Welcome**: Mr. Braswell called the meeting to order at 9:20 am, and welcomed all of the participants to the Annual Meeting.
   - **B. Introductions**: Mr. Braswell introduced the facilitator, Diane Burbie. Donna Yutzy, listed on the agenda, was unable to attend due to an accident. Ms. Burbie is familiar with the Commission and has facilitated meetings in the past.

Roll Call (**Present)**: Aviña, Ballesteros, Bailey, Braswell, Chud, DeAugustine, Frye, Giugni, Goodman, James, Johnson, Land, Liso, Long, O'Malley, Page/Goddard, Peterson, Simon, Washington-Hendricks, Watt

3. **APPROVAL OF AGENDA**:

A. Public Comment, Non-Agendized: There were no comments.

B. Commission Comment, Non-Agendized: There were no comments.

C. Agenda Review:

- Ms. Burbie noted the agenda was ambitious. The morning would review the current CPP and committee functions. The afternoon would address three key initiatives, then the day's information would inform discussion on the new CCP.
- She noted presentations represent the culmination of significant Commission work. Commissioners can take pride in how the work comes together to support enhancing the next iteration of the CCP.

MOTION 1: Approve the Agenda Order ***(Passed by Consensus)***.

4. **2009 – 2011 COMPREHENSIVE CARE PLAN (CCP)**:

A. Objectives Status/Progress:

- Mr. Goodman and Ms. Watt presented on the CCP. It is required by HRSA every three years. The next Comprehensive Care Plan, due in 2011, will cover 2012 – 2014. This meeting was designed to initiate discussion on meeting CCP goals that explore: Where are we now? Where are we going? How do we get there? How do we know if we got there?
- The 2009 – 2011 CCP was in the packet along with a summary of its goals and objectives. Core goals are: Health Outcomes, Service Delivery, Responsiveness, Unmet Need, Service Coordination, Collaboration, Quality of Care, Service Effectiveness, Cost Efficiency, Leadership Development, Information Technology and Reducing Barriers.
- The table lists objectives, indicators, impact and responsible party for each goal. The overall Health Status goal, e.g., is to improve identified health outcomes (health status, quality of life and self-sufficiency) for people in care by a net of 25% and with decline for fewer than 15% by 2011.
- Ms. Watt emphasized the importance of responsible party collaboration in reaching goals. She noted the system of care has faced severe funding challenges with State cuts, and yet has managed to hold its own.
- Mr. Vincent-Jones added that these goals were designed to be tracked with data from the Performance-Based Contract Monitoring Program (PBCM). That program was not fully in place, but data should be available for the next CCP. This was the first CCP in this format. It will be possible to compare year-to-year data going forward, but always in arears.
- Service Delivery goals are outlined in primary health, medical, coordination, access, counseling/education, barriers, residential and HIV testing/counseling. These goals are in number of clients served in the Ryan White-funded system.
- Some medical indicators reflect critical planning, e.g., funds for Health Insurance Premiums/Cost-Sharing (HIP/C-S) have been allocated and funds for Oral Health and Mental Health (MH), Psychiatry have been increased. Ongoing Medical Care Coordination (MCC) implementation addresses coordination, and residential services are being revised.
- Mr. Chud said many in SPA 4 need services especially for MH, Psychiatry. Ms. Watt replied it is important to realize this is the map for moving forward. Today many have lost insurance they had through their jobs and are unaware of how to access available services. It is our job to educate them about access.
- Several asked about financial projections to increase the number of people served. Ms. Watt replied financial expenditure reports are used to estimate costs. Increased demand prompts allocation review to support services.
- Mr. Giugni asked if goals are revised to reflect funding cuts. Mr. Goodman replied they are not. Ms. Watt added the CCP is a road map for the entire County. Many agencies are absorbing programs of importance to consumers such as work force re-entry that are not supported through the Ryan White/County funds.
- Responsiveness includes goals for adversity sectors and MCC. The purpose of adversity sectors is to address unique challenges in an area, regardless of whether it conforms to a SPA or District, and by populations. The separate allocation for SPA 1 was a first effort to address such challenges. SPA 1 data is not yet available as the new services have not been implemented. There has been a poor response to the "adversity sector" term, so it may need to be changed. As indicated earlier, MCC implementation is ongoing.
- On Unmet Need, Ms. Watt noted increased HRSA and Ryan White application focus support the Commission's efforts. Outreach planning has been widely discussed in response to the estimated number of undiagnosed, and a plan has been approved. Ms. Watt added agencies routinely incorporate outreach in their daily work, even though it is not a contract.
- Service Coordination includes goals for coordinated planning, service availability, care/prevention planning and benefits access. Coordinated planning has gone forward with an improved HIV LA Resource Directory and resource

inventories, though utilization maps are not completed. This is an accomplishment considering that Service Provider Network funding was eliminated during this time. Mr. Vega-Matos said the Resource Directory hard copy will be updated after system changes are final, but the electronic version is updated routinely as information is available.

- Mr. Simon asked about the Collaboration goal for housing to consolidate Ryan White and HOPWA administrations. Ms. Watt said the National HIV/AIDS Strategy collaboration mandate for Federal bodies has energized this goal. A retreat was scheduled for the following week to address this issue and should provide a framework for further discussion.
- Ms. Watt felt one key area of improvement was better Commission/Prevention Planning (PPC) Committee coordination including establishment of a joint committee. She encouraged people to keep in mind the National HIV/AIDS Strategy and County goals to reduce incidence, find the undiagnosed and retain people in care. The CCP should be a living document that is referenced and utilized throughout its life to guide service improvement.
- ➲ Ms. Watt will assist Mr. Sotomayor develop a request to OAPP for a progress update on implementation of the SPA 1 special allocation for the November Consumer Caucus.

B. LA County HIV/AIDS Continuum of Care (CoC):

- Mr. Vincent-Jones noted the Commission's first CoC was adopted in 2002. It was the first time the Commission formalized relationships among services, and established common terminology and basic system goals. The 2005 CoC simply revised the 2002 iteration to improve usability of the graphic.
- Full system planning began in 2007. Unlike a closed system such as Kaiser, the Ryan White-funded system is open with multiple providers. The first issue was to identify similarities and differences between closed and open systems, as well as a better understanding of what system planning could accomplish.
- The process began with a series of systems theory classes attended by the Commission members and representatives from the PPC, OAPP and other stakeholders. The goal of these classes was to look at patient flow diagrams and system mapping. Work was not designed to create a new CoC, but the new version developed organically from the work.
- The 2002 and 2005 CoCs only reflected five principal service clusters, each trying to accomplish different goals and objectives, e.g., the medical core addressed medical needs and wraparound services were supposed to bring people into medical care. Services were described and classified in the pertinent cluster.
- Services are only one part of the 2009 CoC. A true CoC should not only describe services, but also what they should do and how they achieve change for those in the system with projected outcomes. The 2009 CoC reflects services from the Ryan White-funded system, those in other health systems, in the community and non-HIV-specific services used by PWH.
- The planning process began with systems mapping, which demonstrates how each service contributes to a client's adherence to care and how to maximize health care benefits to accomplish as much as possible for patients/clients.
- The 2009 CoC addresses how services help people move through the system of care with the patient flow diagram. It represents the system goal of keeping those who enter the system in care and ultimately adherent.
- The system goal is designed to maximize impact as defined by the three health outcomes: health status, quality of life and self-sufficiency. Services, called interventions in the Coc, have been re-clustered to facilitate quantifying system features. Not all desired data is available now, but the framework lays out what can be measured, how data can be used and what information it will provide in order to guide data collection, data systems and methodologies.
- The new clusters are: residential, barriers, counseling/education, access, coordination, medical and primary health. The system is open-ended, so can include prevention, as is being discussed by the Commission/PPC Integration Task Force.
- The broader clusters include services from outside the Ryan White system, which facilitates planning to ensure Ryan White is funding of last resort as required by legislation, e.g., development of benefits specialty and health insurance premium/cost-sharing services.
- There are also five spheres of services: prevention, community support, support services, primary health care and in-patient health care. Some are specific to PWH services, such as primary health. Community support services are those often accessed by PWH, but not specifically designed for them, such as food pantry. Including such services facilitates planning, such as the nutrition support review currently underway, to determine how best to allocate limited funds.
- Systems dynamics modeling exemplifies system flow from when a PWH is unaware, to aware, to in care, to adherent. The goal is to move PWH to adherence, but the system acknowledges flow in the other direction, such as when a PWH drops out of care. It is important to quantify both to plan how to encourage movement toward adherence. The model also reflects the prevention goal to move people at high risk to low risk, which is also being addressed by the Commission/PPC Integration Task Force.
- Every aspect of the 2009 CoC has quantifiable indicators, so a specific practice can be examined to see if it moves those in the system towards adherence. Planning will choose which practices are most important to review at any given time.

6. **COMMITTEE HANDBOOKS**:

- Mr. Johnson said the committee handbooks document processes used to accomplish work. Clear processes are needed for good succession planning and to help new members and the community understand how the Commission works.
- The handbooks are the first step in documenting these processes so that everyone can help keep work on track, and understand what other components of the Commission are doing.

A. Joint Public Policy (JPP) Committee:

- Mr. Engeran-Cordova said JPP is the sole joint committee of the Commission and PPC. It is charged with helping to coordinate discussion on care and prevention policy issues.
- Ryan White is the founding legislation for the planning council (Commission). JPP has routinely been involved in developing thoughts on authorization/reauthorization and has issued a well-received paper on the subject.
- JPP reviews major Federal initiatives such as the National HIV/AIDS Strategy and bills pertaining to HRSA and the CDC.
- There is quick response to State activity, whether it is a threatened line item veto or Office of AIDS (OA) actions.
- JPP is actively engaged in local policy issues, e.g., County activity regarding corrections or commercial sex venues.
- Fiscal concerns at the Federal, State and local level are routinely monitored with updates provided to the Commission.
- Current priorities are Federal and State ADAP issues, Medicare/MediCal/Medicaid and SSI/SSDI. Subcommittees and work groups are also working to identify pertinent health care reform issues. For example, the upcoming election will result in a new governor and insurance commissioner that will affect discussion of how to implement health care reform. One pertinent issue could be advocating for routine HIV screening in certified California insurance plans.
- JPP holds an annual policy agenda meeting, generally in July, to develop an agenda and priorities. Recommendations are presented to the Commission and PPC for approval. Recommendations not already included in the County's policy agenda are forwarded to the Chief Executive Office for inclusion. JPP hosts a legislative review meeting in February or March to to review all relevent proposed State legislation.
- Some current JPP priorities are: State Title 22, reform of regulation of residential facilities for the chronically ill; STD control in the adult film industry; routine HIV testing; comprehensive sex education; and an educational brief regarding navigation points for undocumented and legal resident PWH to access services.
- JPP works to establish collaboration with community stakeholders, many of which attend meetings. The Committee also educates the community with a series of briefs on major topics.

B. Operations Committee:

- Ms. DeAugustine and Mr. Johnson reported that the Operations Committee is charged with the oversight of the Ordinance 3.29 (governing the Commission) and the Commission By-Laws. It is beginning to review the Ordinance, which sunsets in 2011. It also works to facilitate Commission functions through pertinent policies and procedures, which are key for a large body such as the Commission whose work is committee-driven.
- Another major charge is membership management. The body has 39 voting and 3 non-voting seats. Ryan White legislation mandates that a minimum one-third of the body comprises unaffiliated consumers. That third must also reflect the disease burden in the County, e.g., ethnicity and gender. All HIV+ members may also have an Alternate.
- The Operations Committee engages in continual recruitment, especially among populations harder-to-reach populations, such as Latinos. The Executive Committee, with Operations participation, has established a Latino work group, but all should assist.
- The Open Nominations Process includes an application and scoring for new and renewal membership candidacies, along with an interviewing process. Operations also reviews applications forwarded by committees for non-Commission committee members. Recommendations are forwarded to the Commission and, if approved, go forward to the Board for appointment.
- Evaluation and assessment of the membership is ongoing to ensure the best possible planning for LA County. The Committee works to ensure necessary skills and expertise are represented on the body, e.g., public policy experience. Renewal applications include a self-assessment to help hone individual member abilities. Attendance is also routinely monitored.
- HRSA requires a Comprehensive Training Program (CTP). A new CTP has been developed with on-line eligibility training to inform prospective applicants about Commission basics. There are also County- or Commission-required trainings, e.g., the Brown Act and HIPAA. Finally, there are components for: the Commission Orientation, required of new members; Leadership Development and Personal Growth and Continuing Education.
- Ryan White legislation and HRSA also require an Assessment of the Administrative Mechanism (AAM), which assesses efficacy of the administrative mechanism. Operations employs a two-stage approach with a comprehensive AAM

followed by a more in-depth study of a particular topic. There is currently a Procurement Reform Work Group addressing past AAM recommendations to help streamline that process to get services on the street more quickly.

- In addition, Operations oversees parliamentary services, policies and procedures development, and public awareness. The Committee is also discussing how to develop alternate sources of funding, e.g., an affiliated support organization.

C. Priorities and Planning (P&P) Committee:

- Ms. Watt noted P&P increases its meetings from monthly to more during the Priority- and Allocation-Setting (P-and-A) process. P&P presents its work to the Commission at each step of the process.
- She noted some community members and consumers routinely attend P&P, but given the importance of the work and the size of the County, she would like to see more people representing areas from across the County.
- Mr. Goodman said Ryan White legislation mandates planning councils perform priority- and allocation-setting and comprehensive care planning. HRSA guidance also mandates other responsibilities such as a consumer needs assessment.
- P&P applies the lenses of the 15 special populations to its work to ensure their unique needs are addressed.

D. Standards of Care (SOC) Committee:

- Ms. Palmeros presented on the SOC, which works to ensure consumers have an extended life with the best possible quality of life. It is responsible for the CoC, which evolves to be as responsive as possible to consumer needs.
- SOC develops standards for the 33 service categories through Expert Review Panels (ERPs), which include providers, consumers and other experts. SOC revises and updates standards on a regular basis, and will begin reviewing service descriptions to ensure consistency with their respective standards.
- Evaluation of Service Effectiveness (ESE) measures: Customer Perspective, via the Los Angeles Countywide HIV Needs Assessment (LACHNA); Internal Perspective on health, patient and unmet need outcomes via OAPP's annual Performance-Based Contract Monitoring (PBCM); Financial Perspective, via a financial model that incorporates service utilization, cost reimbursement, expenditure and other data; and the Innovation Perspective on best practices, which relies on provider input.
- SOC will being reviewing OAPP aggregate PBCM data for Quality Management (QM) assessment of system strengths, weaknesses and ongoing performance improvement on a quarterly basis. QM helps the Commission identify when additional resources, technical assistance, standard revisions or additional planning may be beneficial.
- SOC is also responsible for the system-level grievance process. OAPP responds to individual consumer grievances.
- SOC works with OAPP on rate study methodology and to ensure consistency with standards, but not actual rates. Currently no rate studies are scheduled.
- Research and evaluation subjects are developed into articles and presentations. These are often derived from the CoC.
- SOC works closely with other committees and work groups, including on Unmet Need and Testing and Linkage to Care (TLC+) initiatives.
- Mr. Chud asked if the Commission would be able to influence the new State Insurance Commissioner to adopt the standards for managed care. Ms. Palmeros said it would be part of their work on the health care reform initiative.
- Ms. Washington-Hendricks expressed concern about increased patient load and reduced funding as they relate to standards. She asked about provider input, in particular regarding nutrition support.
- Mr. Vincent-Jones indicated that the new policy the Commission approved the prior month on standards development and oversight outlined that ERPs are used for formal updates every four years. SOC chooses ERPs from a list of potential provider, academic, public-private and consumer participants reflecting geographic, ethnic and gender diversity. Providers constitute 50% to 60%.
- Revisions may be done in the interim if needed. SOC does not usually use an ERP for revisions, but may choose to do so. Otherwise, revisions are done in Committee. All such meetings are open and participation is welcome.
- SOC brings initial standards, reviews and revisions to the Commission for both public comment and approval.
- Ms. Watt said standards reflect need which does not change with resources. Mr. Vincent-Jones noted one of P&P's recommendations from the last P-and-A process asked SOC to consider if and when available resources should be a consideration. Ms. Watt suggested a joint P&P/SOC meeting for that purpose.

E. Consumer Caucus:

- Mr. Johnson and Mr. Land presented on this newer body developed to enhance the consumer voice on the Commission and provide a safe place for HIV+ Commissioners to discuss issues that arise out of their service.
- Caucus meetings are not covered by the Brown Act or recorded. This is important for consumers who discuss deeply personal aspects of their lives while representing the consumer voice at the Commission table.
- The Caucus is not a committee, so does not have a standard work plan. It does have specific tasks, e.g., the SPA "Meet the Grantee" meetings provide consumers an opportunity to talk to OAPP management without providers present. The Commission developed a grid of issues raised by consumers, but follow-up actions have not yet been clearly identified.
- Dr. Sayles affirmed the value of "Meet the Grantee." She noted actions are difficult to identify in a grid as input often effects change across a range of services and programs, e.g., SPA 1 input on logistical, geographic and cultural issues directly impacted how the SPA 1 RFP for multiple services was written.
- The Caucus also helps consumers identify how best to bring their perspective on various topics to various stakeholders, e.g., committees, providers, academic experts and County officials. Consumer leadership development is addressed in the CTP.
- Mr. Sotomayor presented a phone book of SPA 1 physicians developed by SPA 1 consumers. Consumers hope to encourage greater availability in SPA 1, so they would not need to travel to the San Fernando Valley for services.
- ➲ Dr. Sayles and Mr. Land will develop a reporting format to better communicate OAPP action on issues raised through the "Meet the Grantee" process to facilitate consumer confidence in the efficacy of their involvement.

F. Executive Committee:

- Ms. Bailey and Mr. Braswell presented on the Committee whose membership includes the Commission and committee co-chairs, three at-large members and the Director of OAPP. The Parliamentarian and Executive Director also participate. Meetings are on Mondays 10 days prior to Commission meetings. Its charge includes meeting management and multi-committee collaborations.
- The Committee is responsible for organizational planning and coordination, including the annual work plan, succession planning, the Memorandum of Understanding (MOU) with OAPP, and strategic planning.
- The Executive Committee is charged with much of the organizational management, including setting fiscal guidelines and reviewing fiscal performance. It manages human resources, including Commission office and Executive Director performance.
- It is also charged with part of the Ryan White Part A application, especially the Letter(s) of Assurance, and stakeholder relations.
- Mr. Braswell emphasized the Commission's work is important for consumer health, but can be daunting especially in a time of diminishing resources and new challenges. On his and Ms. Bailey's behalf, he thanked all for their service.

8. COMMISSION INITIATIVES:

- Ms. Burbie noted that many subjects had been raised, especially operational issues, in the morning session and were not on the afternoon's agenda, so she encouraged people to contact Mr. Vincent-Jones with their suggestions to ensure they are not lost.
- Plans and associated documents on the three Commission Initiatives were included in the packet. The presentations were meant to provide input for the work groups that will ultimately outline focus areas for CCP goals and objectives.

A. Unmet Need: Ms. Watt noted the Unmet Need Plan in the packet which was part of the Ryan White application. It has three components: estimating, assessing and addressing unmet need. She encouraged particular work group attention on the last component to improve programs to meet need.

B. Testing and Linkage to Care (TLC+) Treatment Plus:

- Dr. Sayles, Medical Director, OAPP, noted TLC+ is a holistic approach to HIV prevention, medical and support services. The concept developed out of studies showing PWH who were tested and entered into care with Antiretroviral Therapy (ART) had lower viral loads and enhanced their health, while reducing HIV transmission to others.
- TLC+ is a community-level health intervention aimed at increased personal health and fewer new infections. It uses a strategy to identify those who are unaware they are HIV+ along and facilitate their access to optimal HIV care and treatment.
- It also targets prevention in several ways. Those diagnosed who enter treatment are less likely to transmit the virus. There is also an opportunity for those who test HIV- to receive post-test counseling, risk reduction behavior interventions and referrals to services that will help keep them HIV-.

- Elements are not new, but TLC+ places them in a more integrated and streamlined approach. They are: ensuring HIV+ individuals know their status, effective and timely linkage to care for PWH, effective and timely linkage to preventive services for high-risk HIV- individuals, re-engaging those lost to the system of care, evaluating eligibility for ART, effective efforts to support retention in care and ART adherence, and reduction of HIV transmissions.
- There are evidence-based studies for both the model and its elements. There have been numerous studies of HIV transmission in serodiscordant couples which have evaluated transmission rates in various scenarios, e.g., immune status of the PWH partner, stage of HIV infection, and whether the HIV+ partner is on ART. A meta-analysis of 27 studies done in Africa, Europe, Canada and the US showed HIV+ partners with <400 copies had 0 person/year infections.
- ART is already used to prevent perinatal HIV transmission. Nationally, the perinatal HIV transmission rate has been reduced to 2%. Los Angeles County had no documented perinatal HIV transmissions in 2009.
- Another body of evidence-based literature began with a 2009 *Lancet* mathematical model of the effect of a test-and-treat scenario on HIV transmission in South Africa. It proposed universal testing with immediate treatment for those testing HIV+ and ART within 5 years for all testing HIV+. South Africa has a generalized, primarily heterosexual epidemic with a prevalence rate of 18%. The study concluded that by 2016, incidence and mortality would move to an elimination phase of less than 1% and prevalence would drop to less than 1% within 50 years.
- This and similar studies in other populations formed the basis for the HAART model, which is a complement of different modalities combined to reduce the epidemic. These include ART and STI treatment, behavioral change, biomedical strategies and prevention within a social justice and human rights framework.
- It is estimated that there are 12,900 HIV-infected people who are unaware of their status in LA County. CDC estimates that 54% of new infections nationally come from 20% to 25% of those unaware of their HIV+ status. One reason is that viral load spikes shortly after infection. Studies also show that people do change behavior after learning their status.
- Including HIV testing in regular medical care and targeted testing for those not receiving such care are both cost effective means to identify the unaware, since treatment is less expensive at early stages. It is generally accepted that $50,000 per Quality Adjusted Life Year (QALY) is cost-effective, which translates to an HIV prevalence rate of 0.05%.
- 2002-2004 SHAS data is older, but does reflect that a majority of the County's African-Americans and Latinos receive HIV and AIDS diagnoses within a year of each other and large numbers receive them almost concurrently.
- OAPP provides testing data in its *HIV Counseling and Testing Annual Report*. There were about 74,000 tests done in 2009 with a positivity rate of about 1% for all testers and a rate of about 0.87% for those who had not previously known they were HIV+. The rate goal is 1% to 1.5%. It is purposely set higher than the general population rate to reflect reaching those most at risk. The full 2009 report is expected shortly and will be available on the OAPP website.
- There are multiple testing programs, including some 25,000 tests done in Department of Public Health STD clinics with about a 0.81% rate and routine, opt-out testing programs mostly at community-based clinics with about a 1% rate. There is testing in jails, but results have been disappointing. Procedures are being adjusted to improve the rate.
- Targeted testing includes programs contracted through OAPP to do HIV Counseling and Testing in store fronts, mobile testing units and multiple morbidity testing units which have rates of 1.1% to 1.5%. Bath houses and sex clubs test at about 1.5%. There are also court-ordered testing programs and HIV clinic testing, especially of partners.
- It is accepted that linkage to care improves health. Recent studies focus on the most effective linkage to care models.
- For example, a strengths-based case management intervention to assist those who have tested HIV+ to access care was run in ten United States cities. About 80% entered care in the first six months, which was an improvement over baseline. Aspects that influenced entering care were: age over 25, Latino, stable housing, no recent injection drug use, session attendance and co-location of HIV medical services and testing.
- Peer navigation is an emerging linkage approach based on a cancer care model which, similar to HIV care, involves multiple providers and services requiring coordination for best outcomes. The County has replicated a HRSA Special Projects of National Significance (SPNS) on peer navigation for PWH that showed promising results despite a small sample size.
- Data from 1/2006 to 6/2008 shows about 66% of those in the County diagnosed with HIV and 67% of those diagnosed through OAPP-funded testing sites are linked to care within one year (defined as receiving a viral load or CD4 lab result). Approximately 1,200 were identified, focusing on the 679 newly identified. Linkage rates improved over time.
- Differences relate to: race/ethnicity, especially among African-Americans, by gender, risk group, age and testing site, especially in SPAs 4, 6 and 8. OAPP data showed lower rates in the 50+ age group and younger groups Countywide showed lower rates—possibly due to different test sites. PPC-defined priority population linkage rates are: homeless, 41%; MSM, 69%; MSM/W 66%; MSM/IDU, 71%; IDU, 42%; Women at Sexual Risk, 73%; transgenders, 54%.

- Activities to improve linkages are: higher HIV counseling and testing reimbursement rates for linkage; rapid testing two-test algorithm at several test sites; routine testing at clinical sites co-located or closely coordinated with care sites; transitional case management at County jails; and the new non-occupational Post-Exposure Prophylaxis (PEP).
- In addition, OAPP is providing training in strength-based case-management for the Partner Services Program run through the STD Program. **A program is being developed to work with newly identified youth and that will use testing data to identify and contact new cases in collaboration with providers in order to link the youth to care.** OAPP is also reviewing options for peer navigation, e.g., through a couple of NIH-funded studies.
- While linkage is the first step, retention and engagement in care is the goal. OAPP reviewed those among the 2006-2008 679 newly diagnosed and found 81% of those linked to care stayed in care for twelve months (using the HRSA definition of a minimum of two visits in twelve months at least three months apart). About 82% of the 12,725 people in the Ryan White-funded care system in Year 19 also stayed in care.
- Recent literature shows PWH life expectancy can be equivalent to the general population when T-cells are >500, especially if they are >500 for more than five years. It is also less expensive to care for those with higher T-cell counts.
- The "+" in TLC+ means "Treatment Plus" pertaining to treatment guidelines. When to initiate ART changed from <350 to <500 T-cells as benefits have been shown to outweigh toxicity risks. The panel determining the treatment guidelines was split on whether to generally recommend ART for those with >500 T-cells. Regardless of T-cell counts, ART received an top recommendation for those who are pregnant, are co-infected with Hepatitis B, or have HIV-associated nephropathy (renal conditions).
- One study **reported in the *New England Journal of Medicine*** supporting these changes reviewed outcomes for a cohort of **17,517** from 1996 to 2005. **Of 8,362 patients with CD4 counts of 351-500, 25% initiated ART and 75% deferred. The deferred group experienced a 69% increase in risk of death. Of 9,155 patients with CD4 counts >500, 24% initiated ART and 76% deferred. The deferred group experienced a 94% increase risk of death.**
- Community Viral Load (CVL) is a population-based, biologic measure of the total viral burden which can be scaled up to a large area or down to, e.g., a neighborhood or clinic. It is an indicator of effective prevention and treatment.
- County geomapping is not complete as not all data has been input to eHARS. OAPP has done some analysis of those in the Ryan White-funded system for Year 19. Of these, 72% had at least one medical provider visit and 72% were undetectable. The mean viral load was 16,798 with higher viral loads for: newly diagnosed, aged 12-24, Africa-Americans, Native Americans, transgenders, incarcerated/post-incarcerated, and substance using overall although IDUs were somewhat lower. Those who stayed in care and on ART had lower viral loads.
- One of the County's challenges is coordinating care over the 4,000 square miles, which is much larger than other major jurisdictions. The County also has a fragmented health care system, resource challenges, HIV stigma and homophobia. A coordinated HAART strategy, not medical care alone, is needed to address the epidemic.
- Mr. Engeran-Cordova suggested one of the barriers to TLC+ is system processes, such as the level and amount of data required for testers or the linkage requirements for programs. Dr. Sayles said OAPP is reviewing how to streamline options.
- Mr. Land noted a high correlation between homelessness and IDU, averaging about 41%. He asked how substance abuse was being addressed. Dr. Sayles agreed it is a key driver of the epidemic and linkage to care issues. She said many linkage to care activities noted are funded by the National Institute of Drug Abuse (NIDA) and focus on substance users. She said about 75% of PWH County arrests are for substance-related charges, so it is key to interrupt that cycle.
- Mr. Land said he participated in youth support groups at the LA Gay and Lesbian Center 20 years ago. Nearly everyone in the group was homeless, on the streets and/or engaged in survival sex. Addiction plays a major role. He felt youth interventions have faltered. Dr. Sayles agreed and added it was important to divert those at high risk, e.g., meth users.
- Mr. Butler asked if OAPP estimates the number of newly identified infections who receive care through private insurance. Dr. Sayles replied OAPP matches testers with surveillance data, so all those linked to care are captured.
- Mr. O'Brien noted their STD clinic serves many PWH and encounter clusters often traced to website chat rooms. He suggested tracing such communities. Dr. Sayles said OAPP's Partner Services Program works with STD Programs to review "seeds" or initial core transmitters of a sexual network. These PWH surface since they repeatedly contract STDs.
- They are targeted for intensive intervention, and public health investigators attempt to map networks. OAPP also used genotype samples from 3,000 Ryan White-funded system PWH to identify five clusters with 5 to 34 people over six years. OAPP is mapping and defining the clusters. So far, mapping has shown that where people work, sleep and play are not necessarily the same. She noted the necessity of evidence-based interventions more effective for that group.

- Ms. DeAugustine said she was surprised that routinized testing yielded high results. Dr. Sayles responded that a key reason is because OAPP selected community clinics in high disease burden areas. There are plans to expand to urgent care clinics and emergency departments since at-risk populations often do not access regular care.
- Mr. Ballesteros asked about support for staffing at varying care levels, e.g., two versus four visits per year. Dr. Sayles noted two visits are standard for those not yet on treatment or suppressed at least two years. Each clinic's patient population differs, e.g., one with mostly poor, uninsured patients with advanced disease will have more visits than one with economically more stable, healthier patients. She agreed that those differences need to be factored into support for the system.
- Ms. White supported more STD and HIV testing collaboration. Dr. Sayles said the CDC supports program collaboration and service integration. OAPP is working to offer all clients HIV, syphilis, gonorrhea/chlamydia and hepatitis screening.
- Mr. Smith reported the Joint Commission/PPC Integration Task Force is an effort to review how the bodies can work better together and how some activities can be integrated. It has been meeting for about a year. The Task Force drafted notes from its first TLC+ meeting, in the packet, and anticipates additional input from the Commission and PPC.
- Some aspects: Testing – Education, e.g., interventions to promote TLC+ and prevent sero-conversion of high risk HIV-, Early Identification, best practices from other jurisdictions and diseases, optimal mixes of screening and testing types; Linkage – PEP/PrEP, e.g., use and promotion, special populations, jail-based programs review; points of entry such retesting to link HIV+ into care and outreach/education in emergency rooms, patient visits such as provider help to dialogue with PWH on prevention; Care + Treatment – Systems Planning, e.g., incorporating TLC+ into the CoC, efficacy studies, defining best practices for those not using medications properly, biomedical prevention studies, impact Analysis, such as using CVLs to forecast transmission patterns.

C. Health Care Reform:

- Mr. Engeran-Cordova noted JPP convened a work group on health care reform to identify key County and HIV-related issues.
- Issues were grouped into: Estimate, e.g., how many HIV+ Medi-Cal patients will move to managed care; Assess, e.g., provider readiness for health care reform implementation, impact on the undocumented, 1115 Waiver and remaining barriers for those with pre-existing conditions; Address, e.g., oral health/psychiatry availability, ADAP, and changes in CARE/HIPP.
- Mr. Chud asked if political landscape changes may change or repeal health care reform. Mr. Engeran-Cordova said the assumption for planning is that what was passed will essentially be the same when most provisions begin in 2014.
- Mr. Butler asked about the 1115 Waiver. Mr. Engeran-Cordova replied that the 1115 Waiver is currently under review, and is an agreement negotiated with the Federal government on how Medicaid can operate in California. It includes mandatory enrollment of the HIV population into managed care under Medicaid/Medi-Cal.

10. 2011 – 2013 COMPREHENSIVE CARE PLAN:

A. Work Groups:

- Ms Burbie broke the body into five discussion groups, each including consumers and providers. She emphasized the goal was to review the 2009-2011 CCP in light of the information presented during the day on testing, unmet need, health care reform and other issues, but not operational issues.
- Groups should review key issues and determine whether to: 1) stay the course, 2) change course or reflect changes already made, and/or 3) add new issues, priorities or directions.

B. Summary/Reports:

- Stay the Course:
  - Revisit all items.
  - Revisit all items through the filter of health care reform.
  - Revisit all items through the filter of National HIV/AIDS Strategy and TLC+.
  - Revisit all items through the filter of economy and new PWH service needs, e.g., housing, counseling, oral health.
  - Revisit all items through the filter of paradigm shift to fewer resources/more need as it affects leadership and providers.

- Review/Revise/Change Course:
  - Make no distinction between prevention and care in CCP so that case identification and linkage is part of the CoC.
  - Incorporate a true, revitalized public awareness/outreach campaign with no distinction between care and prevention, so that people know that services are available and ready to help them learn their status and get care.
  - Change from individual responsible parties to a statewide strategy with collaboration that engages the State Office of AIDS, OAPP, private providers, Chief Executive Office, Department of Health Services. Lead or get out of the way.
  - Collaboration with Medicaid system, especially as health care reform absorbs the system, to ensure patients are not lost to system.
  - Collaboration among all the Ryan White parts, especially Parts A and B.
  - Major emphasis on how the system will transition 70% of PWH into managed care from provider and patient perspectives.
  - Ryan White calls for 5 million HIV tests nationally per year. Establish a stretch goal for 350,000 public and private tests per year, which is the approximate County share of the national goal.
  - Emphasis on those unaware of their HIV+ status and collaborative efforts to bring them into care.
  - Emphasis on determining what the Ryan White system will look like after health care reform implementation, especially related to provision of wrap-around services and of services for those excluded from health care reform.
  - Cut red tape to facilitate community providers to do the work they know, especially in serving populations such as transgenders and women, for which other providers often lack expertise. Redirect red tape savings to services.
  - Recognize services for the undocumented as a public health issue and develop a strategy to ensure services.
  - Recognize the undocumented community and design a system to identify/count care not provided due to eligibility.
  - Eliminate redundancies in and barriers to planning and funding across prevention and care.
  - Make CCP process more flexible and adaptable to better respond to changes as they occur.

- New Issues/Priorities/Directions:
  - Expand use of technology to improve collaboration, such as data sharing, in order to facilitate CCP implementation.
  - Use technology to initiate single entry points for all systems and services to eliminate redundancy.
  - Focus on appropriate implementation of MCC as first step prior to setting CCP benchmarks.
  - Identify and track other resources, such as other Federal funding streams, to maximize planning efforts.
  - Consider how to respond if Ryan White ceases to exist.
  - CCP should recognize that there is a capacity limit to the system regardless of whether resources decline or the number of people in the system increases. CCP can address limits through prioritized services, financial caps or other measures.
  - CCP must be able to adjust and bend to strategize new scenarios as they arise.

11. SUMMARY AND CLOSING:

- Ms. Watt said that the P&P CCP Work Group is open. She encouraged those who participated today to join. She noted some will likely object when work comes to the Commission. Those here now should stand up for the process.
- ➲ The following joined the CCP Work Group: Ms. Bailey, Mr. Baker, Mr. Ballesteros, Mr. Braswell, Mr. Chud, Mr. Engeran-Cordova, Ms. Forrest, Mr. Fox, Ms. James, Ms. Kiburi, Dr. Long, Ms. Peterson, Ms. Washington-Hendricks, Dr. Sayles, Ms. Watt, Mr. Wise, Ms. Wu

12. ANNOUNCEMENTS: There were no announcements.

13. **ADJOURNMENT**: Mr. Braswell adjourned the meeting at 4:20 pm. There was no closing roll call.

MOTION AND VOTING SUMMARY		
MOTION 1: Approve the Agenda Order.	***Passed by Consensus***	**MOTION PASSED**